

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 7, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The physical medicine/rehabilitation **was found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 8th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 09-17-03 through 11-10-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of September 2004.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/pr

July 26, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

Patient:

TWCC #:

MDR Tracking #:

IRO #:

M5-04-2931-01

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Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a woman who injured her arm on ___ through the repetitive use of her right arm. She was seen by Dr. B who diagnosed tenosynovitis of the hand and wrist and prescribed Vicodin. She was seen by an orthopaedist for severe tendonitis of the right forearm and index finger. He noted that she was on oral steroids, Celebrex and Daypro, without relief. He recommended therapy with iontophoresis and use of a wrist brace and continued occupational therapy, which she did three times a week. On May 17, 2000 she had an EMG that reported severe injury to the medial nerve at or about the level of the pronator teres muscle. She was placed on Neurontin. Dr. P

recommended continued therapy until June 19th when he recommended pronator release on the right.

Dr. P performed the release on July 6, 2000. Post surgery she was on pain medications, wrist brace and other therapies. Therapy was interrupted by abdominal pain/hospitalization in August. She started therapy with Dr. T. On September 27th, Dr. P diagnosed her with chronic pain. On October 2nd, Dr. T diagnosed her as having possibly sympathetic median nerve pain and recommended right-sided ganglion block, which was carried out October 14, 2000 by Dr. S. She continued therapy in October of 2000. She was on Elavil and changed to Effexor.

In October she was put on Klonopin and a chronic pain management program was recommended. She continued therapy. On November 14th Dr. O felt she was having a major depressive disorder and recurrent and chronic upper extremity pain. He recommended modifying her program. The chronic pain management program was denied by the carrier. She was continued and in December of 2000 occupational therapy was discontinued and she also had psychological peer review which stated that the depression was primarily pre-existing and that summer Dr. W felt she should not benefit from the chronic program. She continued to require medical management and recommendations for her chronic problems.

The carrier was denying psychological problems associated with her injury. Finally, the carrier did approve the patient for the chronic program which was started in September 2003. Her program was interrupted through other health issues not related to work and then her treating doctors applied for continuation of the program, which was granted. The carrier denied payment on the therapies between 09/17/03 and 11/10/03, stating that it was not medically necessary. ____, director of support services, supplied documentation of the summary of the course of events associated with providing service as well as financial coverage for service.

DISPUTED SERVICES

Under dispute is the medical necessity of physical medicine/rehabilitation from 09/17/03 – 11/10/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The treating facility has provided medical documentation that indicated that they have met the usual treatment guidelines and care standards and had obtained preauthorization with the carrier prior to starting the program. The carrier has responded with a statement that per physician review, the treatment was not medically necessary without further details. From the records provided, the reviewer was unable to find and details for denial. The documentation does not support the denial of medical services. The medical services provided to ____ were medically necessary.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding this finding by US Postal Service to the TWCC.

Sincerely,